

Pediatrics & Parents

The newsletter for people who care for children

Richard J. Sagall, MD, Editor

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Caries in Breastfed Infants

Is there a relationship between unrestricted breastfeeding and dental decay? There are a few studies that have suggested a relationship, but haven't concluded such a relationship exists. A recent analysis of data from the 1999-2002 National Health and Nutrition Examination Survey (NHANES) disputes the earlier findings.

Early childhood caries (ECC) is defined as one or more decayed, missing, or filled tooth surfaces in children under 72 months of age. A child with severe childhood caries (SCC) has at least one filling or cavity on a primary maxillary incisor.

Unfortunately, the research found that 27% of the children were classified as having ECC and 10% had SCC. But, the good news is that unrestricted breastfeeding had no impact on the chances of a child having either ECC or SCC. Factors associated with ECC and SCC include older age, being of Mexican American heritage, living at or below the federal poverty level, and being exposed to maternal smoking in utero.

Pediatrics, 10/07

Alcohol Advertising Works

Alcohol advertising and promotions result in increased drinking in adolescents. That's the finding from a study of 1,080 sixth, seventh, and eighth graders who said they had never consumed alcohol. Twenty-nine percent of these children owned or wanted to own an alcohol-related promotional item such as a hat, shirt, bag, etc. These children were classified as "highly receptive." Twelve percent had a "favorite" brand of alcohol – even though they were non-drinkers – and were classified as "moderately receptive." The rest of the children were classified as "not receptive."

The study found that the moderate and highly receptive children were 77% more likely to consume alcohol in the following 12 months than the not-receptive kids. Twenty-nine percent of the children admitted to drinking alcohol during the follow-up period; 13% reported drinking at least one drink one or two days in the previous 30 days.

According to Lisa Henriksen, PhD, the lead researcher, "Alcohol advertising and promotions are associated with the uptake of drinking." She recommends reducing advertising aimed at children and teens, limiting promotional items, and teaching children to be skeptical about sponsors' marketing programs.

Journal of Adolescent Health, 01/08

Why Are Adolescents Violent?

By James Garbarino, PhD

Why are adolescents violent? The simplest answer is this: they are violent because as children they did not learn non-violent strategies to meet their needs and respond to emotions like anger, frustration and fear. Of course most adolescents – indeed most human beings of any age – are capable of violent behavior. The success of military training in producing soldiers who are capable of lethal violence “on command” is evidence of that. But the main story when it comes to adolescent violence starts in childhood.

Virtually all children express aggressive behavior in infancy and early childhood, so the real issue is not “how do children become aggressive?” but rather “why do some children continue to be aggressive and thus set the stage for becoming violent teenagers?” Research reveals that the two principal processes that control the developmental pathway for aggression in childhood are the ideas a child learns about aggression (“cognitive structuring”) and the experiences a child has in situations where aggressive behavior is modeled and reinforced (“behavioral rehearsal”).

Some children receive consistent messages that reduce the legitimacy of aggression (“don’t hit”), while others receive messages that legitimize aggression (“fight back when attacked” and “aggression is successful”). Similarly, some children observe parents, siblings and peers resolving conflict non-aggressively while others observe abuse and fighting. Just mapping patterns of cognitive structuring and behavioral rehearsal helps explain why some kids arrive at adolescence with a high level of aggressive behavior while others don’t. We must always remember that virtually everyone who commits an act of violence believes it is justified – at least at the time the act is committed. All this helps explain why boys have traditionally engaged in more physical aggression than girls.

Girls have been taught “girls don’t hit” and have been generally excluded from situations where they could practice being physically aggressive, whereas boys have been taught “boys do hit – it’s just a matter of learning who, when and where to hit” and have been welcomed into situations where physical aggression is normal (most notably competitive sports). And these same processes help explain why the gap between boys and girls in the matter of physical aggression is narrowing as girls are told and shown that “girls do hit” and have a chance to participate in settings where they can practice being physically aggressive.

The ratio of girls’ to boys’ participation in high school sports in the past 30 years has changed from 1:32 to 1:1.5. This statistic may help explain why the ratio of male-to-female arrests for assaults changed in the last 20 years from 10:1 to 4:1, and research on the effects of televised violence on aggressive behavior in children shows that in the 1960s girls were immune to the effect but now show the same effects as boys.

The kids most at risk of bringing a pattern of serious childhood aggression into adolescence are those who have developed a chronic pattern of bad behavior and violating the rights of others, kids who might be described as meeting the criteria for what mental health professionals call “conduct disorder.” Research on the links between “risky thinking” reveals that the odds that a child will develop conduct disorder reflect the intersection of being abused and having lower levels of social information processing (being hypersensitive to negative social information and oblivious to positive social information, as well as having very limited ideas of alternatives to physical aggression as a social tactic and carrying around the belief that aggression is a successful social tactic).

Knowing all this, what conclusions can parents draw? The first of these conclusions is that no matter how effective, motivated, and attentive any of us is as a parent, our children go to school with kids who are prone to behavior violently—some of whom have access to lethal weapons. There are kids – mostly boys – in every school who have developed a pattern of aggressive behavior, who have established an internal state in which they see themselves as victimized by peers and society, and whose emotions and moral judgements have become harnessed to their aggressive rage. These youths can make the transition to murder readily if weapons are available and they reach a crisis state. Knowing how these kids reach this point and what we can do reclaim them empowers us to reduce the odds that they will commit acts of lethal violence. Thus, violence prevention is everybody’s business.

My second conclusion is that the problem of lethal youth violence usually starts from a combination of early difficulties in relationships that are linked to a combination of difficult “temperament” and negative experience. Every parent who knows children knows that children come equipped with different temperaments. Some are sunny and easy; others are stormy and difficult. Some children are easy to parent; others are

very challenging. Some children are so difficult that no “normal, average” parent will be able to succeed without expert professional advice and support. When it comes to developing patterns of aggression, some of the difficulties lie in being impulsive, emotionally insensitive, having a high activity level, being of less-than-average intelligence, and being relatively fearless.

These temperamental problems do not spell doom, however. What matters is how well the parenting and educational experiences of these children meet the challenges posed by their difficult temperaments. Of special concern are two patterns. The first is a pattern of escalating conflict in the parent-child relationship, in which parent and young child get caught up in mutually coercive and aversive interactions. The second is a gradual process of emotional detachment that arises when parents and teachers abandon these children by withdrawing from them in the face of their negative behavior.

These patterns of response increase the odds that these vulnerable children will become increasingly frustrated and out of sync as they meet up with the challenges of paying attention in school. In a culture like ours, in which there is such intense cultural imagery that legitimizes and models violence, this emotional abandonment is particularly dangerous. Parent education that starts before children are born and continues through until adolescence is crucial for preventing violence.

When children get off track in early childhood and start to exhibit high levels of aggressive behavior, they are candidates for joining and supporting aggressive and anti-social peer groups that build negative momentum throughout childhood and into adolescence. This can be avoided. For example, research by Sheppard Kellam and his colleagues demonstrates that if the first grade classroom is well organized and provides clear messages about behavior, aggressive kids are reclaimed and their aggressive behavior tamed. If the classroom is chaotic, these boys form negative peer groups and their problems with aggression intensify. Our own “Let’s Talk About Living in a World With Violence” has demonstrated its ability to reduce aggression among third graders when used by a teacher who is comfortable dealing with issues of aggression and who integrates these concerns (and the program materials) into the general classroom curriculum.

Children whose difficult temperament and experience put them on track for problems with aggressive behavior need help from parents and teachers to learn to manage their behavior. Teachers need special skills and a high level of motivation to create classroom environments that prevent violence.

Research shows that patterns of aggression start to become stable and predictable by the time a child is eight years old: unless we do something to intervene, children identified as aggressive at this age will tend to be aggressive 30 years later (they become adults who are violent in their families, get involved in fights in the community, and drive their cars aggressively).

My third conclusion is that the most common pathway to this pattern of aggression at age eight is that temperamentally vulnerable children tend to be the victims of abuse and neglect at home and, as a result, develop a negative pattern of relating to the world in general. This maltreatment can be both physical abuse (beatings) and psychological abuse (rejection).

The negative pattern that results has four parts. The children are 1) hypervigilant to the negatives (such as threatening gestures) in the social environment around them; 2) oblivious to the positives (such as smiles); 3) develop a tendency to respond aggressively when frustrated; and, 4) draw the conclusion that aggression is successful in the world. According to research by psychologist Kenneth Dodge and his colleagues, this negative pattern is the most potent link between a child being the victim of maltreatment and developing a pattern of chronic bad behavior and aggression (what will be diagnosed by mental health professionals as “conduct disorder”). Being abused produces a seven-fold increase in the odds of developing conduct disorder. About a third of these children with conduct disorder will eventually become violent, delinquent youth (and about 90% will go on to demonstrate some serious problem in adulthood). In juvenile prisons, typically about 80% will have shown this negative pattern. Child abuse prevention is the cornerstone of preventing lethal youth violence.

My fourth conclusion is that troubled kids will be as bad as the social environment around them. I have identified this as the issue of “social toxicity,” the presence of social and cultural “poisons” in the world of children and youth, to which troubled kids – boys and girls—are especially susceptible. Just as asthmatic children are most affected by air pollution, so “psychologically asthmatic” children are most affected by social toxicity.

The glorification of violence on television, in the movies, and in video games is part of this social toxicity, and it affects aggressive kids more than others. The same is true for the size of high schools. Academically marginal students are particularly affected in a negative way by being in big schools (with more than 500 students grades 9-12). The availability of drugs and guns is another example. Mobilizing community

leaders, parents, professionals, and youth themselves can provide a rallying point for improving the social environment. Detoxifying the social environment of children and youth is essential to protect children and youth from the problem of lethal violence.

My fifth conclusion is that at the core of the youth violence problem is a spiritual crisis. Human beings are not simply animals with complicated brains. Rather, we are spiritual beings having a physical experience. This recognition directs our attention to the multiple spiritual crises in the lives of violent adolescents. They often have a sense of “meaninglessness,” in which they feel cut off from the sense that life has a higher purpose. By the same token, they often have difficulty envisioning themselves in the future. This “terminal thinking” undermines their motivation to contribute to their community and to invest their time and energy in schooling and healthy lifestyles. Finally, they often have lost confidence in the ability and motivation of the adults in their world to protect and care for them. This leads them to adopt the orientation of “juvenile vigilantism.” A teenager says, “If I join a gang I am 50% safe; if I don’t join a gang I am 0% safe.” The point is that adults don’t enter into the equation.

Non-punitive, love-oriented religion institutionalizes spirituality and functions as a buffer against social pathology, according to research reviewed by psychologist Andrew Weaver. On the other hand, the shallow materialist culture in which we live undermines spirituality

and exacerbates these problems. One way to deal with these issues is to have schools join with community leaders to embrace the National Character Education Campaign, as developed, for example, by psychologist Thomas Lickona. Character education offers all positive elements within a community a focal point for their actions. It provides a framework in which to pursue an agenda that nourishes spirituality without invoking Constitutionally insoluble issues of church and state.

Over the past 25 years there has been a doubling of the percentage of children and youth who have mental health and developmental adjustment problems severe and chronic enough to warrant professional intervention, according to the research of psychologist Tom Achenbach. The spreading problem of youth violence is related to this larger development. Dealing with this will require multiple strategies. These include seeking every opportunity to mobilize the community on behalf of non-violent messages and values. It will include intensive but compassionate intervention with troubled aggressive children in childhood to prevent the pattern from becoming deeply entrenched as they enter adolescence.

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Shopping Carts Dangers

By Sara Jo Poff

The dangers of shopping carts prompted the American Academy of Pediatrics (AAP) to release a report in August 2006 that asked that shopping carts be redesigned and for parents to consider alternatives to putting their children in them. Since shopping carts have been used for decades, it’s easy to wonder why the AAP is suddenly so concerned about this issue.

To put it simply, their studies have shown that there are too many preventable injuries from these metal four-wheeled baskets. Findings from emergency rooms all over the country show that more than 24,000 children were treated in 2005 alone for shopping cart-related injuries. Seventy-nine percent of these children were younger than age five, and 92% were younger than just one year old. Most of the injuries were to the child’s head and neck, two vulnerable body parts, and forty-five percent of these injuries were fractures. And since

1985, five deaths have been reported due to shopping-cart incidences.

Children sustain injuries from shopping carts in a variety of ways. Aside from falling out of the cart (usually onto linoleum, concrete, or asphalt), children are injured by the cart tipping over when they hang onto the outside, by becoming entrapped, by striking a cart, and by being run over by a cart. Most importantly, siblings play a huge role in the likelihood of cart accidents. In fifty-six percent of cart tip-overs, a sibling was involved. Surprisingly, parents were present in more than ninety percent of these episodes. Because of these findings, it is simply not enough for parents to use these carts with the notion of maintaining adequate supervision.

Are these risks enough to make parents avoid using shopping carts for their children? The AAP feels strong-

ly enough about these preventable injuries that they asked doctors to regularly inform their patients about these dangers. A child is much more likely to sustain a shopping cart-related injury than be harmed at school. But unless a parent has experienced a traumatic incident or seen one happen, it may be easy to overlook the dangers. Since it would only take one time of forgetting to buckle in a child or for a child to quickly grab onto the outside of the cart for an accident to happen, the AAP has recommended other options instead of using shopping carts for children.

Their first recommendation to parents is to find someone to stay home with the children while shopping or to have another adult come shopping with them. When another adult isn't available, the AAP recommends that parents use strollers, wagons, or front packs for children, especially young children that are at a much higher risk for injury. When buying a lot of groceries, for example, carriers, slings, and front-packs allow parents to still have both hands free to push a cart. Kid-friendly carts, such as car-shaped ones, are much safer than traditional ones because the center of gravity is usually lower, which makes the cart more stable. Beware, however, that these carts also contain a child seat in the traditional spot on the cart where parents often put smaller children, especially babies. And, infant car seats should never be put in these front child seats. The possibility of these carts tipping over predisposes the infant to tremendous risk, especially when placed in the highest point of the cart where the center of gravity is highest.

Another option parents now have is that of online grocery shopping while their children play, nap, or eat in the comforts of their own home. Extra-busy parents can even shop late at night or early in the morning. And since many companies offer home delivery, it saves parents the hassle of loading and unloading their vehicle full of kids and groceries.

Parents are asked to consider these options until newer, more stable designs for carts are required and implemented. In the U.S., the Consumer Product Safety Commission (CPSC) determines the safety for cases like these. But in 1975, 1994, and 1998, the CPSC denied petitions to lower the instances of cart tip-overs and petitions by improving restraint systems in carts. Their response was markedly different from European standards where, in 19 countries, safety specifications are required for shopping carts, including tests to determine the cart's stability.

In addition to needing a more stable wheelbase, all carts should be mandated to have a passive restraint system. The two types of restraint systems, active and passive, both provide mechanisms for securing a child

into the seat. An active restraint is a belt, buckle, or harness that the parent manually (i.e. actively) uses to fasten the child. Currently, these are the restraints most often found in shopping carts. Passive restraints, on the other hand, are designed to automatically secure a child upon entering the seat. Additionally, these restraints can be designed to prevent the cart from moving when the restraint is not in use. Unfortunately, the CPSC also denied a petition to implement this type of restraint in 1994.

The need for passive restraint systems is illustrated by a study that was conducted to determine the effects of public awareness for child restraints. When concentrated efforts were made through flyers, signs, and announcements to educate the public about the importance of shopping cart seatbelt use, the study found only a one to fourteen percent increase in seat belt use. When a representative for the study approached shoppers and asked them to use the seatbelts for their children, fifty-one percent decided to use the restraints. While that was an astounding difference, one of two children still were not restrained using the active restraint system when personally approached.

When considering shopping cart safety, in addition to the risk of a child being injured by or in a cart, parents may also want to consider the exposure to bacteria and germs on shopping cart handles that expose them and their children to a different kind of danger. It's worth parents' time to creatively approach shopping in a new way and to make sure their children are as safe as possible. And, until carts are redesigned, parents shouldn't be afraid to mention their concerns about a store's carts to the store manager. Let him know that there's a need for change.

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Births Around the World

Countries with the most births per year.

(Million births in 2005)

India.....	24.1
China	16.7
Nigeria.....	5.3
Indonesia.....	5.0
Pakistan	4.4
Bangladesh.....	4.3
U.S.A.	4.1
Brazil.....	3.1
DR of Congo	2.7
Ethiopia.....	2.7

U.S. Census Bureau



Children in Hospitals

By John E. Monaco, MD

The Simple IV?

To many it seems like such a simple concept. Admit a sick child, start the IV, administer fluids and medications and wait for the child to get better, right? How hard can it be? Well, one of the great ironies of caring for sick children in the hospitals is that one of the most basic steps in hospital care can be one of the most challenging.

Luckily, most people manage to get through the long and difficult process of raising their children without ever having to go through the trauma of experiencing the hospitalization of their child. Those who have gone through the trauma of seeing their sick child in the hospital will tell you that one of the most harrowing experiences is watching the ER staff or the pediatric floor staff attempt, and hopefully succeed, in drawing blood and starting IVs. It can be long and arduous, and unfortunately painful, process.

Picture this: Your nine-month-old otherwise healthy child has been vomiting for two days, and over the last 24 hours has also developed diarrhea. You have been talking to your pediatrician and she says to give only clear liquids, slowly and frequently. You manage to get a couple ounces in over two or three hours and suddenly your child vomits again. He is more listless than he was earlier in the day. And all the time he continues to have loose, frequent diarrhea stools. You begin to panic. What am I going to do? How long can he go on vomiting and having diarrhea and not drinking? You call the pediatrician. It is late in the evening and the office is closed. She tells you to bring the child to the Emergency Room of your local hospital.

You get to the ER; you wait an hour, maybe two, to be seen. You keep trying to give your child Pedialyte, but he's losing interest as quickly as he is losing energy. Finally, a very nice nurse comes back to you and escorts you to a room. The ER doc comes in and immediately says the your child looks very dehydrated, and we'd better get an IV in right away.

Two nurses come in. They tell you that you can stay, but you might not want to. You decide to stay because you have never left your baby. One of them holds your

child and the other starts "to look for a vein." She looks at the back of your baby's hand and grumbles that he is either too chubby or too dry. You take offense but want to stay supportive. She looks at the ankles and again grumbles at the lack of possibilities. Then, in your horror, she looks at your baby's scalp. It turns out that this is one of the best sites in a child under a year. You go along, and amidst the desperate screams of your beloved child, now in the hands of strangers, you watch as a completely focused nurse threads a tiny IV catheter into one of the spidery looking veins in your baby's scalp. You can't believe that she got it in. You can't believe that she seemed to be unaffected by the screams. You can't believe that this seemingly simple procedure stands between life and possibly death for your baby.

But it does. The most valuable person in any pediatric ER, on any pediatric ward, ICU or any other setting where kids get sick, is the nurse, or doctor, who is proficient at getting IVs in kids. Without that skill, or talent, almost nothing else in pediatric hospital care is possible.

IV starting is learned by practice, which means that there will be times when your child is having his IV started by someone who is doing it for the first time. Hopefully, someone who is more experienced and can prevent any mishaps is supervising that individual. A recent wonderful development in medical education is the use of "dummies" or simulators to teach students clinical procedures. These are basically computer-animated patients with veins that need IVs. Much like the concept used in teaching airline pilots, the theory is that a medical student who hones his techniques on a nonliving subject will be much more prepared when the real thing comes along.

Ultrasound technology has developed to the point that veins can actually be visualized at the bedside, making IV starting much easier. Unfortunately, in the case of the tiny veins in pediatrics, this is often impractical. One can only hope the research in adults will eventually trickle down to the more challenging veins of small children.

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Ask "Baby Doc" Eden

By Alvin N. Eden, MD

Exercise

An 18-month-old girl enjoys sitting in her highchair, eating snacks and watching TV. Is there a problem with this?

It depends on how much time she spends in front of the TV, and how much time she spends out of her highchair moving around. I might add that the American Academy of Pediatrics recommends no television watching for the first two years of life.

The majority of infants and toddlers have no problem when it comes to physical exercise. Rather, often slowing them down is the problem. With all their crawling, climbing and cruising, together with their great continuing curiosity, these little people develop and tone up their muscles all day long and often into the night. If given the opportunity and space, their adventurous spirit will take over. Of course, one of the consequences of all this physical activity is the increased risk of an accident. But this fear of accidents should not deter you from allowing your child to move freely around her environment.

However, there is a group of infants and toddlers that does not follow this pattern of activity. There are some children who are more placid, less active and content to sit around a good deal of the time, drinking large quantities of milk and apple juice and munching happily on cookies and the like. Some of this pattern of behavior may be genetic (couch-potato families) but I believe that most of it is environmental, caused by mistakes parents make.

Many of these basically sedentary children are already overweight, having been overfed and overstuffed right from day one. A vicious cycle is established. It really does not matter which came first, the obesity or the inactivity. The fatter the child, the more difficult it becomes to be active; similarly, the less activity, the greater the weight gain.

If a toddler is already obese (one only needs to perform the "eyeball test" by looking at her to know), then something must be done. Her parents should discuss

their daughter's weight with her doctor and ask for suggestions. They should cut down on junk foods such as sugary snacks and apple juice, and make a greater effort to get her moving out of her infant seat or playpen. Similarly, parents should offer a piece of sliced apple as a snack instead of a chocolate chip cookie. And then her parents should play hide-and-seek around the house or engage in another physical activity instead of letting her sit and watch TV.

Another factor that may help a young child become sedentary is the over-protection and over-concern of many parents – more mothers than fathers, for some reason – with his or her physical well-being. I believe that these over-protective parents don't realize the long-term damage they may be causing in terms of the physical and emotional development of their child. By continually discouraging physical activity because of the fear of an accident, parents inadvertently discourage the natural curiosity that is so crucial to healthy development.

Parents should not discourage their toddler's desire to explore, roam and learn. They can cut down on accidents by removing objects that might be dangerous. And, parents should take their children outdoors as often as they can. The more opportunities to exercise her body the better.

Please remember that these little folk are sturdy and strong, and love to be handled and engaged in rough-house activities. Besides a lot of fun, wrestling and tumbling around develops and strengthens all muscles. Remember that little boys and girls are not nearly as fragile as many believe. Obviously, limits must be set to avoid accidents. Encouraging physical activity early on will pay large dividends later on.

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Perspectives on Parenting

By Michael K. Meyerhoff, EdD

Learning Disabilities, Behavioral Disorders, and Boys

Just over 30 years ago, back in 1975, the federal government passed the Education for All Handicapped Children Act, which guaranteed that every child, regardless of disability or disorder, and regardless of severity of disability or disorder, would receive a free and appropriate education at the public expense. That legislation was eventually replaced by the Individuals with Disabilities Education Act (IDEA), which essentially elaborates on that mandate and now serves as the basis for all special education programs in our public schools.

I'm sure that if you asked the average taxpayer on the street what types of "disabled" or "disordered" kids are being served by these programs, he would reply that a chunk of his paycheck is going to help children who are blind, deaf, wheelchair bound, mentally retarded, etc. I think he would be shocked and dismayed to find out that in reality, the overwhelming majority of children in special education today are boys who have been placed there for "learning disabilities" and "behavioral disorders."

What lies behind these statistics? If you buy into the notion that learning disabilities and behavioral disorders are due to abnormalities or deficiencies that are inherent to the child, I think you would be hard pressed to come up with an explanation that makes sense. Are there particular kinds of brain defects that attach themselves primarily to the Y chromosome? Is there something about the male appendage that has a tendency to cause neurological problems?

On the other hand, if you consider that these difficulties can be attributed to factors outside the children, then in my opinion, things start to become rather clear and obvious. Unfortunately, because of the way we socialize our young males and the way we set up their initial school experience, it is almost inevitable that a large number of little boys will be doomed to failure and frustration.

Think about it. During their first years of life, boys are encouraged to be physically active and engage in a lot

of gross motor (large muscle) activities. They are told to run, jump, and climb, and they are praised for being boisterous and aggressive. Meanwhile, during their first years of life, girls are encouraged to be relatively passive and engage in a lot of fine motor (small muscle) activities. They are told to dress their dolls in tiny outfits and hold tea parties with delicate cups and saucers, and they are praised for being quiet and cooperative.

Now think about what is required of children when they enter school. They must sit still and be quiet for long periods of time, and they must pursue a variety of progressively more complex fine motor activities. Girls have been well prepared for this. Regrettably, for boys, entering school is like running into a brick wall. Is it any wonder that they have a great deal of difficulty "getting with the program," and is it unreasonable to expect that they will often "act out" as a result?

To make matters worse, think about who is in charge of the educational experience during the first years of school. Who are all the kindergarten, first grade, and second grade teachers? Women. Little boys must spend the first years of school dealing with a distinctly feminine culture that furthermore is supervised by females who may have a lot of trouble relating to what they are going through. Is it so unreasonable to assume that these female teachers may be too quick to label little boys as "disabled" or "disordered" and ship them off to special education?

There are miniscule numbers of men teaching kindergarten, first grade, and second grade. I have never had the opportunity to do a formal study of this, but I am willing to bet everything I own that if you look at entry-level school classrooms with male teachers, the number of boys being labeled and shipped off to special education is significantly lower than the average.

So what should parents of little boys getting ready to enter school do about this situation? Well, there are two possible approaches to this problem. One involves looking at the small picture, and the other involves

looking at the big picture. Let's start with parents of an individual male child.

There are those who say difficulties arise simply because "boys mature more slowly than girls," so the solution would be to hold back your boy for a year, giving him more time to develop. However, I don't see a lot of evidence indicating significant differences in maturity rates between boys and girls. There is a tremendous amount of evidence indicating that rates and patterns of development among all children vary enormously, so in general, it is wise to wait until any child is developmentally ready for the academic tasks that will be required rather than basing school entrance on something as arbitrary and meaningless as chronological age. Therefore, as a general rule, this doesn't work. Holding a boy back for a year may, indeed, be a good idea in one case, but it also may be unnecessary and inappropriate in another.

An alternative solution might be to better prepare the boy for what he will be required to do when he enters school. That is, encourage him to engage in more sedate fine motor activities. This doesn't have to involve dolls and tea parties, but perhaps channeling his energy into things like slow-paced video games will allow him to practice sitting still and exercising his small muscles. However, this solution also has its shortcomings. There is an obesity epidemic among our young children, and suggesting that any child be less active is inadvisable. In fact, we are – and we should be – encouraging our little girls to do more running, jumping, and climbing.

Consequently, I believe the ultimate solution lies in taking a look at the big picture. We need to restructure early educational experiences so that both boys and girls have an equal chance to succeed. This would involve enticing more men to teach in entry level classrooms and re-training the women who are already teaching there so they can be more aware of potential problems and can make their environments and practices more accommodating and more appealing for little boys.

In the meantime, individual mothers and fathers have to understand the situation and take whatever steps they can to ensure that their little boy is not inaccurately labeled and unfairly banished from the classroom. This means visiting the school to assess the atmosphere, policies, and procedures and to discuss the possibilities for making things more inviting and accessible for their male child. It also means working with the kid at home in ways that compensate for the inadequacies of the current system by presenting lessons in a manner to which a little boy can relate easily and enjoyably.

I'm not saying this will be easy and that it won't be time consuming. But you can look at the statistics and either accept them or seek to understand them. And if you choose to understand them, you realize your parental responsibility to ensure that your child is not improperly perceived and treated as disabled or disordered and to ensure that he is given the equal opportunity to be comfortable and succeed in school to which he and every child is eminently entitled.

See the following sites for the statistics referenced in this article:

www.alliance2k.org/products/4009.pdf

www.nea.org/teachershortage/03malefactsheet.html

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Simple IV – Continued from page 6

Obviously, pain is an unwelcome consequence any time a needle pierces the skin, and is an enormous inhibition to trust in the pediatric population. In the last decade, the use of topical anesthetics, like EMLA cream or other lidocaine-containing creams, have been a tremendous help in IV starting in kids. These creams are applied to the skin over the vein to be used for the IV. It takes a few (up to 30) minutes, but the surface skin will eventually become numb. The obvious limitations to this technique are time, in an emergency situation, or when multiple attempts are needed to even "find" the vein. Still, you should not be afraid to ask for your child to receive one of these creams, if time and the severity of illness allow.

Still, there is hope on the horizon. But even with all these techniques designed to make IV insertion easier, less painful and more successful, getting the IV started remains one of the most important first steps in caring for almost any child admitted to the hospital for almost any reason. The IV nurse that tries to find a good vein in your child's body isn't trying to hurt him – or emotionally torture his parents – but help him on his way to recovery.

*John E. Monaco, MD, is board certified in both pediatrics and pediatric critical care. His new book, *Moondance to Eternity*, is now available. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.*



Children's Emergencies

By Martin Belson, MD

Allergic Rhinitis

One of the most common presentations of allergies in children involves the nose and eyes. The clinical condition involving nasal symptoms is called "rhinitis" and allergic involvement of the eyes is called "conjunctivitis." According to the American Academy of Allergy, Asthma and Immunology (AAAAI), allergic rhinitis (hay fever) affects about 40 million people in the U.S., including up to 40% of children.

With the onset of spring and fall, many children begin to exhibit symptoms of seasonal allergic rhinitis, or hay fever due to exposure to outdoor allergens, such as tree pollens, grasses and weeds.

What Causes Hay Fever?

Seasonal allergic rhinitis, or hay fever, is caused when a person's immune system mistakenly identifies an allergen (e.g., pollen) as an intruder, much like bacteria or viruses. Once the body has identified a particular allergen as an intruder, it produces antibodies specific to that allergen. In the future, when that allergen enters the allergic person's body, it attaches to the antibodies and triggers the release of histamine and other chemical mediators of inflammation. This release of histamine and other chemical mediators is what causes allergy symptoms.

How Often Can Hay Fever Occur?

Constant exposure for the allergic individual can cause daily symptoms, resulting in what your physician would diagnose as "persistent, chronic, or perennial allergic rhinitis." Allergens responsible for these chronic symptoms may include house dust mites, mold spores, cockroach allergen, feathers, or indoor pets.

Symptoms of allergic rhinitis can also be acute or intermittent, presenting only when one is exposed to a relevant allergen. It is not uncommon for a cat-allergic individual to have an acute episode of allergic rhinitis when he enters into the home where a cat resides.

Seasonal allergic rhinitis, as its name implies, will manifest itself usually during the pollen seasons, most typically in the spring and fall. Exposure to tree pollens

is generally responsible for late winter and springtime symptoms, and grass pollens are generally the cause of springtime and early summer symptoms. Flare ups in the fall are typically due to weed pollens and high mold spore exposure.

Different people are allergic to the pollen of different plants, but people whose bodies develop allergies to one plant are very likely to develop allergies to others as well.

Can Hay Fever Run in Families?

Allergic rhinitis does run in certain families and is more common in children that have asthma or eczema. It is also more common in children that are exposed to second-hand smoke, air pollution and pets.

What are the Signs and Symptoms of Hay Fever?

- Sneezing
- Runny nose
- Nasal congestion
- Watery eyes
- Itchy nose, eyes, ears and throat
- Headache
- Ear and facial pain
- "Allergic salute" - a common habit of children that consists of rubbing their nose upward. This is usually because the nose is itchy and this practice can lead to a small crease in the skin of the lower part of the nose.
- "Allergic shiners" - dark circles under the eyes caused by nasal congestion

How Does Allergic Rhinitis Adversely Affects Children?

According to the Pediatric Allergies in America survey, which is the largest and most comprehensive national survey of parents of children under the age of 18 who suffer from allergic rhinitis, and presented at the AAAAI 2008 Annual Meeting in Philadelphia, allergies do interrupt a child's productivity, sleep cycle and daily functioning.

More than 500 parents who had a child with allergies were interviewed about severity and effects of allergies

on their child's life, and their responses were compared to more than 500 parents of children without allergies.

Some of the major findings include:

- Allergy symptoms interfere with children's sleep. Forty percent of parents indicated that their child's allergies interfere a lot or somewhat with their sleep.
- Allergy symptoms limit children's activities. Twice as many parents (21%) said allergies limit their children's activities, compared with only 11% of parents whose child did not suffer from allergies.
- Allergy symptoms interfere with children's education. Forty percent of parents of children with allergic rhinitis report their condition interferes with their performance at school compared to only 10% of parents of children without allergic rhinitis.

How is Hay Fever Diagnosed?

Based on the history and physical examination, your pediatrician can make a clinical diagnosis of hay fever. She may then elect to give your child a trial of the basic medications used for treatment. An allergist can also help your child with the immediate symptoms of seasonal allergic rhinitis. And, more importantly, an allergist can identify the pollens to which your child are allergic and then design an effective treatment program to eliminate or minimize allergies in the future.

If the medical history suggests allergic rhinitis, an allergist is likely to perform allergy testing in order to confirm the diagnosis, identify the offending allergen(s), and ascertain the severity of the allergy. The preferable testing method by most allergists is skin testing. This method allows the testing of multiple allergens with the results being available immediately. Alternatively, similar results can be obtained through a blood test called RAST or ImmunoCap.

What Treatment Options are Available?

Once the relevant allergens have been identified, a comprehensive treatment plan will be recommended. Treatment options fall into three categories: environmental control, pharmacotherapy, and immunotherapy. One, two, or all three of these options may be recommended, depending on multiple factors such as the severity and chronicity of symptoms, results of past treatment, and the effect that these symptoms have on one's quality of life.

Environmental Control

One needs to minimize exposure to allergens to which he is sensitive. As simple as this is conceptually, it may be quite difficult, if not impossible, to implement in many cases. The classic case is the child who is cat-allergic and lives in a home with a cat. Removing

the cat from the home can in some cases be curative, but, in reality, there is often great resistance to the recommendation to remove the cat from the home due to the attachment a family develops with a pet, and the resultant emotional issues that can ensue.

Pharmacotherapy

There are many medicines available that are quite effective in minimizing or eliminating the symptoms of allergic rhinitis. These generally fall into the categories of 1) the newer, non-sedating antihistamines, such as Allegra, Claritin, Clarinex and Zyrtec and 2) steroid nasal sprays, such as Nasonex, Flonase, and Nasacort.

Immunotherapy

Immunotherapy (also called desensitization), is the only treatment that addresses the actual cause of the problem. A series of shots are given to lessen your child's sensitivity and reaction to various antigens.

How Can Exposure to Pollen be Minimized?

According to The Allergy and Asthma Center in Atlanta, pollen is the most difficult airborne allergen to avoid, but there are still a number of things that you can do to minimize your exposure to pollen.

Here are some tips from the Allergy and Asthma Center at www.allergyinatlanta.com.

In your home:

- Avoid open windows, attic fans, or any other unfiltered openings for pollen to get into your home. Instead, run your central air or a window unit for air circulation and filtration.
- Replace your furnace filters or wash electrostatic filters regularly to help clean pollen out of the air. You can also use vent filters on the room vents to catch anything that might have made it by the furnace filter or pollen and other allergens that may have already settled in your air ducts.
- Run a HEPA air cleaner in your bedroom to help eliminate the pollen that makes its way into your home.
- Do not dry your clothes on an outside line where they can collect pollen. Instead dry them in a vented dryer.
- Outdoor pets are covered in pollen. Wipe or brush them down when you let them indoors and bathe them frequently. You should also avoid letting them track pollen onto your bed.

When working outdoors:

- Avoid work like mowing the lawn or raking leaves, which stir up even more allergens than are already airborne.

Continued on page 16

The Child with a Febrile Seizure

By James S. Millar, MD

Background

Febrile seizures are common, with two to five percent of children in North America experiencing at least one febrile seizure, the majority of which (at least two-thirds) are simple febrile seizures. The usual age range is between six months and five years of age, with the peak between 18 and 24 months. In 1993, the International League Against Epilepsy defined febrile seizure as "an epileptic seizure occurring in childhood associated with fever, but without evidence of intracranial infection or defined cause. Seizures with fever in children who have experienced a previous nonfebrile seizure are excluded."

The clinical evaluation process is based on both the type of the febrile seizure and the illness that triggered the initial fever. Febrile seizures are broadly defined as "simple" (only one generalized seizure in a 24-hour period with no previous neurological problem) or "complex" (more than one 15-minute or longer focalized seizure in a 24-hour period with previous history of neurological problems).

Risk Factors

The primary risk factors for first seizure are attendance at a daycare center, first or second-degree relative with a history of febrile seizure, developmental delay, and neonatal nursery stay longer than 30 days. Studies have found the male:female ratio to be 14 to 10. For children with any two of the four risk factors there is a 28% chance of at least one febrile seizure. For children with a febrile illness the prime risk factors are the height of the fever and a first or second-degree relative with a history of febrile seizure. Specifically, ten percent of siblings and ten percent of offspring of a child who had a seizure with fever will also have seizures with fever.

The risk factors for recurrent seizures are family history of febrile seizure, duration of the fever, height of

the fever, age less than 18 months, and possibly family history of epilepsy. Ethnicity, gender, neurodevelopmental abnormality, and a complex febrile seizure with one or more complex features are not risk factors for recurrence of febrile seizures. The risk factors for the development of afebrile seizures (i.e. epilepsy) after an episode of seizures with fever are duration of the fever, complex febrile seizure, neurodevelopmental abnormality (cerebral palsy, hydrocephalus), and family history of epilepsy. A possible risk factor is more than one complex feature of the febrile seizure.

More Information

For more information on neurological disorders or research programs funded by the National Institute of Neurological Disorders and Stroke, contact the Institute's Brain Resources and Information Network (BRAIN) at:

BRAIN

P.O. Box 5801

Bethesda, MD 20824

(800) 352-9424

<http://www.ninds.nih.gov>

"Febrile Seizures Fact Sheet," NINDS.

NIH Publication No. 06-3930

Information also is available from the following organization:

Epilepsy Foundation

4351 Garden City Drive

Suite 500

Landover, MD 20785-7223

postmaster@efa.org

<http://www.epilepsyfoundation.org>

Tel: 301-459-3700

800-EFA-1000 (332-1000)

Fax: 301-577-2684

One study had data finding 10% of the population developing an afebrile seizure disorder after seizures with fever. Ethnicity, gender, family history of febrile seizures, age at first febrile seizure, and height of the temperature are not risk factors for the development of subsequent epilepsy. These factors are important after the initial febrile seizure to reassure the parents after the episode, and to direct any additional evaluation. These factors are beneficial for recommendations for care of the patient who has experienced a repeat seizure with fever after the acute episode.

Evaluation

The initial component of the evaluation of the febrile child with a seizure is the same as for any child with a fever. These measures consist of a medical history, including chronic illness, recent antibiotic use,

recent immunizations, and daycare attendance. Infants less than three months of age who appear well and present with a temperature above 38°C (100.4°F) are reported to have a 10% chance of serious bacterial infection or meningitis. Two percent of the infants and children over three months of age with a temperature above 39°C (102.2°F) are found to have bacteria in the blood stream.

Current recommendations include consideration of a spinal tap, especially in children less than 18 months. The prevalence of meningitis among patients with a febrile seizure was found to be between one and two percent, and the absence of any remarkable findings on the history or physical examination make bacterial meningitis unlikely as the cause of the fever and seizure. Other laboratory studies, such as serum salt levels, are most beneficial in situations with clear symptoms or signs of a concurrent illness, such as diarrhea and/or vomiting.

The electroencephalogram (EEG) has not been found helpful to predict the likelihood of developing afebrile seizure disorders later in life. A neurology consultant is rarely needed for the child with a febrile seizure, especially the simple febrile seizures. Neuroimaging (cranial magnetic resonance imaging (MRI) or computed tomography (CT)) is indicated in the child with a febrile seizure and evidence of increased intracranial pressure, history and/or examination suggestive of trauma, or a possible structural defect (in cases of microcephaly or spasticity).

Treatment

Recommendations for treatment have been published for the treatment of the child with a simple febrile seizure. These evidence-based reports do not recommend the use of continuous or intermittent therapy with either neuroleptics or benzodiazepine for the after care of a simple febrile seizure. No medication has been shown to reduce the risk of an afebrile seizure (epilepsy) after a simple febrile seizure.

James S. Millar, MD, is associate professor and medical director in the Department of Family Medicine at the University of Oklahoma-Tulsa College of Medicine. He received his medical degree from the University of Oklahoma College of Medicine, Oklahoma City, and completed a residency in family medicine at the University of Oklahoma-Tulsa.

Read to Your Children

Not enough parents read to their children. A report from Boston's Reach Out and Read National Center found that only 48% of parents of children under age five read to them every day. According to Dr. Shirley A. Russ, the lead author, "Early learning starts at home with parents. We need to do more to ensure that parents have the information and tools they need to provide their children with a strong foundation for learning."

The report compared the level of reading to children zero to five years old in each state with each state's reading performance figures for fourth graders. States

with high levels of parents reading to their children show high levels of reading performance at the fourth grade level, and states with low levels of parents reading to children had lower levels of reading ability at the fourth grade level.

The researchers found many factors that influenced the results. Geography was important. High percentages of parents living in New England read to their children, and children in New England scored above average in reading proficiency. Parents in the South read less to their children and their children, when tested in the fourth grade, score below average.

Other significant factors are household education level (the higher the education level of the parents, the more likely they were to read to their children), household income level (the higher the income level, the greater the chance the parents read to their children), race/ethnicity (55% of white parents, 38% of black parents, and 33% of Hispanic parents read to their children every day).

According to Dr. Russ, "The more words parents use when speaking to an eight-month-old infant, the greater the size of the child's vocabulary at age three."

The Center's program, Reading Across the Nation, helps parents learn of the importance of reading to their young children. "Compared to families who have not participated (in the program), parents who have received Reach Out and Read are significantly more likely to read to their children, and they have more books in their homes," says the report. At age two, these children show a 4-8 point increase in vocabulary tests, approximately a six-month gain over average.

Visit their website, www.reachoutandread.org, to learn more about the program.

Pediatric News, 12/07

Percentage of Live Births Classified as Low Birth Weight

Mexico	9.4
Japan	8.6
Hungary	8.4
Greece	8.1
U.S.	7.8
United Kingdom.....	7.6
Portugal.....	7.4
Luxembourg	6.8
Slovakia.....	6.7
Germany	

Organization for Economic Co-operation and Development

Your Questions Answered

Roy Benaroch, MD, answers your questions this month. He practices in Atlanta, GA and is a frequent contributor to the newsletter and the Pediatrics for Parents podcast. Sharon Fried Buchalter, PhD, is a distinguished clinical psychologist, family/marriage therapist, relationship expert and author.

Send your questions to QandA@pedsforparents.com or Pediatrics for Parents, PO Box 219, Gloucester, MA 01931. Please keep them general in nature as we can't give specific advice nor suggest treatment for your child. All such questions should be asked of your child's doctor.

MRSA - Part II

Last month in this column, I answered a related question about MRSA (methicillin-resistant *Staph aureus*.) We're getting many questions about this in my office and through *Pediatrics for Parents*, and unfortunately the news media isn't always painting an accurate picture about this problem. Let's set the record straight by answering a few more questions about MRSA.

Cellulitis is one way that staph (including the resistant MRSA) can cause infections. It occurs just underneath the skin, usually through a small break like a scratch or insect bite. The area will be warm, red, and tender. Usually, the child doesn't feel feverish or ill – but if your child has a cellulitis plus a fever or feels quite ill, you ought to seek medical attention immediately.

There is a cure for staph infections, including cellulitis. The MRSA that is becoming common in many communities can be treated with several different antibiotics, including Bactrim, Cleocin, and doxycycline. As long as your child is evaluated in a timely manner and the staph infection is recognized and treated appropriately, the response to therapy is usually very good.

It's also important for your doctor to culture any pus that is collected. By sending some of the infected material to the lab, the kind of bacteria can be identified and the best antibiotic to treat it can be confirmed.

Most children who have MRSA infections respond fully to therapy and do not have recurrences. If the infection does return, special strategies to help completely eradicate the infection can include bleach soaks, taking multiple antibiotics, using special soaps, and perhaps using an antibiotic cream in the nose. With these methods, MRSA can be eradicated for good – though sometimes it may take several tries. Continue to work with your child's pediatrician if recurrences occur, or ask for a referral to an infectious disease specialist.

Roy Benaroch, MD

Protein Powder

Q Is protein powder an adequate substitute for milk for kids?

A Milk for children is primarily a source of four important nutrients: protein, calcium, vitamin D, and vitamin A. Of these, only protein is found in abundance in protein powder; in fact, there can be such a concentrated amount of protein that if these powders are consumed without extra water, kidney damage can result. Anyone who uses commercial protein powder supplements should always follow the package instructions carefully. Protein powders will not supply a child with the other important nutrients found in milk, so they are not a suitable substitute for milk.

Roy Benaroch, MD

Exercise

Q I'd like to get my family into some sort of exercise regimen. My husband thinks I'm being too structured. Obviously there will be overall health benefits of keeping us in shape, but can you tell us the other benefits of exercise and what positive improvements we can expect to see?

A We are all well aware of the physical benefits of exercise, but there are remarkable psychological benefits as well. Exercise is one of the best ways to decrease stress. With less stress, many individuals will begin to feel more energized and alive. Exercise also helps improve self confidence and body image. By exercising regularly, most people begin to see positive physical change. When people start seeing these results, they are proud of their success and feel good about who they are. This, in turn, enhances body image perception and self-confidence.

Exercise makes most people feel good and when people feel good, their moods seem to elevate. When we exercise, endorphins are produced in the brain and re-

leased into the body. Endorphins are thought to relieve stress and pain naturally, giving people a euphoric and invigorating feeling. Studies have shown that regular exercisers have a more positive outlook and are happier overall. The main point is that exercise not only improves physical health, but also mental health. Unit-ing the physical and psychological benefits of exercise helps enhance quality of life.

It is also important to remember that you are a role model for the rest of your family. If you spend most of your time on the couch, you can expect your children to do the same. Therefore, make exercise a family event. Being a healthy role model is one of the best ways to get your kids active on a regular basis. Always make exercise fun and enjoyable for everyone. Try activities that will raise heart rates, such as a game of tag, family bicycle rides through the park, or an evening walk around the neighborhood. Best of all, you and your family can spend quality time together and also stay healthy. This can do wonders for everyone's overall well-being and mental health. So get motivated, get moving and get fit – your family will thank you for it!

Sharon Fried Buchalter, PhD

Eczema

Q My child has eczema. Will intense moisturizers help the problem? What other remedies do you suggest?

A Eczema is chronic, itchy rash of childhood. In babies, it's mostly on the cheeks; in older kids, it might be mostly in the elbow and knee folds – but at any age, it can occur almost anywhere.

Moisturizers or emollients can certainly help. Choose one that is free of perfumes and preservatives. Plain Vaseline® (petroleum jelly) works well, and it's cheap. The best time to apply a moisturizer is right after a bath, while your child's skin is still wet. Other ways to increase the skin's moisture is to avoid soaking in soapy water, run a humidifier in the winter, and avoid rough scratchy clothes.

Other strategies that help with eczema include topical medications. The best medicines to use for most children are topical steroids. These are very safe and very effective when used correctly. Generic versions of most of these are available and they work well. Usually, the ointment forms of these medications are more effective and less “stingy” than the creams. There are many topical steroid products available at many different strengths, so work with your pediatrician to find one of these that's strong enough to treat your child's eczema well.

If your child seems to need a highly potent product, you ought to consult with a dermatologist for guidance. Though topical steroids are safe, you should avoid using oral steroids to treat all but the most super-severe eczema. And if oral steroids are needed, your child ought to be seeing a specialist.

It's also important to treat the itching that accompanies eczema. This is done with topical medication, soothing cool cloths, and sometimes oral medicines. Occasionally, eczema can flare up because of an infection in the skin, and a short course of oral antibiotics will be needed.

Some, but not most, children with eczema have one or more food triggers that worsen the rash. These can be difficult to find, as the effects of foods can be delayed. Sometimes, very common foods can be a trigger. If your child's eczema is moderate-to-severe, or you find it difficult to treat the eczema with safe medications and moisturizers, you may want to work with a physician skilled in eczema and allergies to try to find possible food triggers.

Roy Benaroch, MD

Australian Junk Food

The ncreasing rate of childhood obesity isn't only a problem for American youths. According to the Australian Medical Association (AMA), about a quarter of Australian children and adolescents are overweight, with one in four of the overweight children classified as obese. Just like in this country, junk food is a big part of problem.

According to Rosanna Capolingua, MD, president of the AMA, “The marketing and promotion of food that is energy dense and nutrient poor should be prohibited, and banning of junk food ads on TV would be a good start.” She recommends extending the ban to movies, athletic events, and the Internet.

Sounds similar to what medical groups are advocating in this country.

Australian Medical Association, 3/18/08

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Pediatrics for Parents
podcast?**

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Allergic Rhinitis – Continued
from page 11

- Take a shower when you come inside to remove pollen from your hair and skin, and irrigate your nose to remove pollen from your nasal passages.
- Every time you go out your clothes and shoes collect pollen. When you get home leave your shoes by the door and change clothes as soon as possible. This cuts down the time you spend in contact with pollen and the amount of pollen that you bring inside.

When you are going out:

- Keep car windows and sunroofs closed and the air on re-circulate when traveling in your car to prevent pollen from making its way in.
- Keep in mind that pollen is at its worst on windy days, because the wind stirs even more pollen and it travels further. And, pollen is at its best after a prolonged rain, because the rain washes the pollen out of the air.

Martin Belson, MD is a pediatric emergency medicine physician at Children's Healthcare of Atlanta at Scottish Rite, a medical toxicologist, creator/editor of www.kidemergencies.com and host of the Pediatric Health Hour every Wednesday at 9AM on www.radiosandysprings.com. He is also the author of www.kidemergencies.com, a user-friendly, free resource on children's health emergencies and poisonings for everyday mothers and fathers.

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